HIPAA INFORMATION SERIES

8. Trading Partner Agreements

This paper is the eighth in a series of ten developed by the Centers for Medicare and Medicaid Services (CMS) to communicate to the health care provider community key concepts about HIPAA - the Health Insurance Portability and Accountability Act of 1996. This paper focuses on the Administrative Simplification transactions and code sets requirements and the role of trading partner agreements in HIPAA implementation.

TIP: Trading Partner Agreements can provide valuable information about how electronic data interchange (EDI) will be conducted.

Why are trading partner agreements helpful?

Paper 6, "What to expect from your health plans," introduces the concept of the trading partner agreement (TPA). Although HIPAA requires the use of electronic transactions and code set standards, the standards only cover part of the information that trading partners need in order to conduct transactions efficiently. Generally, the standards mandate the format and content for key data elements, but contain no requirements about how the transaction is sent or received -- or what is done with the transaction after it is received. Health plans use TPAs to describe these specific health care data processing requirements. In addition, trading partner agreements:

- Specify EDI processing functions and requirements. They can't change standards in any way.
- Are different for each health plan and payer. This gives the trading partners much needed flexibility.

What will a trading partner agreement look like?

HIPAA defines the standards for the electronic transactions and code sets regulation; however, there is no standard HIPAA format or content requirements for TPAs. A TPA may, or may not, resemble a typical contract. For example, it can be part of a larger agreement, or a stand-alone. Since there are no limitations or specifications on the form or the provisions in a TPA, each agreement will be different and unique to your situation.

TIP: HIPAA does not require a TPA or specify what has to be in the agreement. Your health plans and payers will determine what should be included in their TPAs.

STANDARD TRANSACTIONS

1. Claims or equivalent encounter information
2. Payment and remittance advice
3. Claim status inquiry and response
4. Eligibility inquiry and response
5. Referral certification and authorization inquiry and response
6. Enrollment and disenrollment in a health plan
7. Health plan premium payments
8. Coordination of benefits

Pending approval:

9. Claims attachments
10. First report of injury

Code Sets

1. Physician services/ other health services- **both HCPCS and CPT-4**
2. Medical supplies, orthotics, and DME- **HCPCS**
3. Diagnosis codes- **ICD-9-CM,Vols 1&2**
4. Inpatient hospital procedures– **ICD-9-CM,Vol 3**
5. Dental services– **Code on dental procedures and nomenclature**
6. Drugs/biologics– **NDC for retail pharmacy**

Trading partner agreements are just one communication mechanism. Your health plan and clearinghouse trading partners may choose to use other methods to tell you about changes to formats, data content, and other requirements. These communications may take the form of billing instructions, formal memoranda, or bulletins. Health plans may also develop implementation "companion guides." These guides are used in conjunction with the X12N implementation guides, and like the TPA, address specific electronic data interchange issues unique to that health plan. For more information on companion guides, see paper 6 in this series, "What to expect from health plans."

What might a trading partner agreement include?

Trading partner agreements cover a variety of electronic transaction issues. For example, they may address:

- ❑ Provider identifiers:
  Which provider identifiers will be used in transactions until the National Provider Identifier (NPI) is adopted.
- ❑ Processing requirements:
  Whether transactions will be handled real time and/or in batches.
- ❑ Provider taxonomy codes:
  Whether the health plan will require the provider to submit a provider taxonomy code on the claim.
- ❑ Situational issues:
  How providers should deal with certain situations. Many data elements in the standards are "situational," which means they are required if a given situation is met.
- ❑ Inter-communications:
  The method for accepting and sending transactions. While the standards do address format and data content, the standards do not address how entities trade health information. For example, TPAs will identify clearinghouses, other third parties, or direct data entry arrangements. They may also discuss the use of disks, tapes, dial-up connectivity, or any other electronic connectivity that is supported by the trading partner.
- ❑ Testing:
  Details needed for the testing phase. For example, how testing will be conducted, timeliness of processing test files, and how providers are notified of test results.
- ❑ Contact information: Trading partner telephone numbers and contacts for EDI technical assistance, and provider customer service.

Information & Tools Available at the CMS Web Site

http://www.cms.hhs.gov/hipaa/hipaa2

- Covered entity decision tool
- Provider readiness checklist
- HIPAA Informational papers
- CMS Outreach ListServe
- HIPAA roundtable audio conference dates
- HHS & other external HIPAA links
- Instructional CDs & videos
- HIPAA FAQs & compliance dates
- Complaint submission form

For HIPAA Privacy inquires

http://www.hhs.gov/ocr/hipaa/

or call the Privacy hotline at : 1-866-627-7748

Examples of health plan-specific information

HIPAA implementation guides provide health plans some flexibility to determine what data content to require within a specific format. Thus, two way communication with each of your health plans is a critical part of the HIPAA compliance process. The following are examples of the kinds of health plan-specific information that may be provided in trading partner agreements, companion guides or other special instructions.

- General comments:
  Some comments may expand upon the definitions in the ASC X12N implementation guides. For example, HIPAA requires a specific format for a payee's last name in the 837 implementation guide requirement. One of your health plans might add a comment next to this requirement that states, *"The LAST NAME reflects the information contained in our membership records. If this information is different than what you submitted, you may need to update your records for future claim submissions."*

- Technical tables:
  Health plans may provide tables that detail special technical instructions. The tables may contain a row for each segment that the health plan has something additional (over and above) the information in the implementation guides. For example, a health plan that limits the length of a simple data element might provide a comment that states, *"Claims that contain percentage amounts submitted with more than two positions to the left or the right of the decimal may be rejected."*

- Varying levels of information:
  HIPAA provides the health plans some flexibility within the format to determine which data content to require. For example, HIPAA requires that the eligibility inquiry and response transactions, at a minimum, contain a member's name, identification, and date of birth. The response from the health plan, at a minimum, must contain information indicating if the individual is generally eligible for services as of the date the request was submitted. Keep in mind, a health plan may choose to require additional data for a transaction in certain situations. For example, a health plan may also require specific procedure and diagnosis data, or eligible dates of service in addition to the minimum required for an eligibility transaction.

What to do when you receive a TPA

When you receive a TPA, you should immediately send a copy to the person, office, or billing service, responsible for your electronic claims processing.

HIPAA Deadlines

April 14, 2003
Privacy Deadline
(April 14, 2004 for small health plans)

April 16, 2003
Testing
You should start testing your software no later than April 16, 2003.

October 16, 2003
Electronic Transactions & Code Sets Deadline

NOTE: Medicare will require that all Medicare claims be submitted electronically, with the exception of those from small providers and under certain limited circumstances.

July 30, 2004
National Employer Identifier
(August 1, 2005 for small health plans)

April 21, 2005
Security Deadline
(April 21, 2006 for small health plans)

As a provider, you should make sure all the appropriate individuals review the agreement and address any concerns. This may involve your office's HIPAA "point person," your billing manager, or your legal counsel. When reviewing the agreement, it helps to keep the following questions in mind:

- ❑ Information System / Billing service or other vendor concerns:
  - Can your billing system / vendor accommodate the requirements?
  - Do you have the resources in place to keep up with all the different TPAs from different health plans?
  - What changes are required and at what cost?
  - How much lead time is required to make the changes?
  - Will you be HIPAA compliant by October 16, 2003?

- ❑ Office Staff concerns:
  - Are there manual business processes required by the agreement?
  - Do any office procedures or policies need to change to meet the requirements?
  - What kind of staff training will be needed?
  - Do you have the resources to accommodate the training?

FOR MORE INFORMATION ABOUT HIPAA…

Log onto the CMS HIPAA web site for free educational tools and services:
http:/www.cms.hhs.gov/hipaa/hipaa2

E-mail your questions to askhipaa@cms.hhs.gov

Call our CMS HIPAA HOTLINE 1-866-282-0659